

On behalf of the more than 18 million volunteers and supporters of the American Cancer Society (ACS), I thank you, Mr. Chairman, and your colleagues on the Senate Commerce, Science and Transportation Committee for inviting me to present testimony regarding the status of state-based tobacco control efforts after the Master Settlement Agreement (MSA) and the recent Surgeon General's Report on Reducing Tobacco Use.

I am Francis L. Coolidge, Immediate Past Chairman of the Board of the American Cancer Society. The Society is a co-chair, along with the American Heart Association, of the ENACT (Effective National Action to Control Tobacco) coalition – a public health coalition of more than 50 national organizations dedicated to reducing the death and disease caused by tobacco use. Today, I am representing the American Cancer Society, but I bring to this discussion a broad public health perspective and an understanding of the goals of the public health community in terms of tobacco control and prevention efforts at the local, state, and federal levels.

The American Cancer Society is the nationwide, community-based voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives and diminishing suffering from cancer, through research, education, advocacy and service. Despite the significant recent gains we have seen in decreasing overall cancer incidence and mortality rates, approximately 1.2 million Americans still will be diagnosed with cancer this year and more than 550,000 will lose their battle with the disease. As you know, tobacco use is responsible for nearly one in five deaths in the United States – a needless and tragically preventable loss of more than 430,000 American lives each year. Tobacco kills more Americans than AIDS, drugs, alcohol, car accidents, homicides, suicides, and fires combined. A lesser-known but no less grim fact is that more than 30 percent of all cancer deaths is attributable to smoking and tobacco use.

The American Cancer Society has established challenge goals for the year 2015 – goals that we are pursuing with the cooperation and collaboration of the public, private, and non-profit sectors. Collectively, we hope to reduce age-adjusted cancer mortality by 50 percent, decrease age-adjusted cancer incidence by 25 percent, and markedly improve the quality of life for all people touched by cancer. We know from data and scientific evidence that one of the key steps to achieving an accelerated reduction in

cancer incidence and mortality is tobacco control -- especially when it comes to children -- through meaningful regulation and effective cessation programs that will help those currently addicted to quit.

Mr. Chairman, three years ago next week, the Chief Executive Officer of the American Cancer Society, Dr. John R. Seffrin, testified before your committee about the need for national legislation to protect the health of American citizens from the harms of tobacco. Unfortunately, what was true three years ago, is still true today -- one in three people who dies of cancer dies because of tobacco. These are deaths that could be prevented if our nation seriously and comprehensively addressed tobacco and made a long-term investment in a sustained campaign to prevent tobacco-related disease and death. Even the Supreme Court determined earlier this year that tobacco is "perhaps the single most significant threat to the public health in the United States."

As you know, some minority and ethnic groups and the medically underserved suffer from a disproportionate burden of cancer. Similarly, large differences in tobacco use exist in the United States. For example, in 1997, smoking prevalence was 37.9 percent among American Indian/Alaska Native men, 32.1 percent among African American men, and 27.6 percent among white men. Taking these data into account, it is therefore not surprising that there are marked differences in tobacco-related cancer deaths among different groups within the population. This year, it is expected that the rate of lung and bronchus cancer death for whites will be 49.3 per 100,000 while for African Americans it will be 60.5 per 100,000. No single factor determines the patterns of tobacco use among racial and ethnic groups. Data collected throughout the 1990s found that teen smoking increased by 80 percent among African-Americans; among Hispanics, 34 percent; among Native Americans, 26 percent; and among Asian-Americans, 17 percent. Clearly this cause for alarm. We know that these trends result from complex interactions among many factors including socioeconomic status, acculturation, targeted advertising, price of tobacco products, stress, and varying capacities of communities to mount effective tobacco-control initiatives.

ACS has prioritized the reduction and elimination of the unequal burden of cancer as a top nationwide priority. As part of meeting this challenge, the Society is working at all levels of the organization to advance policies and programs that work to reduce health disparities among minority and ethnic populations and the undeserved. Also, ACS urges policy makers to take action to ensure that disparities in tobacco use and the associated adverse health outcomes are addressed.

Mr. Chairman, on behalf of the Society's nationwide volunteers and staff, again thank you for your ongoing leadership on tobacco issues and for providing us this opportunity to discuss with you and your colleagues the state-based tobacco control efforts in the post-settlement environment.

Public Health Community Vision of Tobacco-Control in the Post-MSA Environment

The American Cancer Society and our partners in the public health community had great hopes that the MSA could have a positive impact on tobacco control in our nation, especially at the state and local levels. As you know, in 1999, ACS joined with our public health partners in calling for the entire amount of the state settlement money to be returned to the states, as long as Congress required a 20 to 25 percent set-aside for state and local tobacco control efforts. This allocation is the amount that the Centers for Disease Control and Prevention (CDC) and other public health experts say is needed to establish the most effective tobacco control efforts. Unfortunately, the Congress waived its right to any of the settlement money without requiring that the states spend any money on tobacco control.

The failure of Congress to ensure that the states would spend a minimum amount of the new money on initiatives to reduce and prevent the use, access, and appeal of tobacco products unfortunately has resulted in a dismal record and wholesale inadequate spending by the states to address the problem of tobacco use. According to a new report produced by the Campaign for Tobacco-Free Kids and endorsed by the American Cancer Society, on average a mere 7.5 percent of settlement money is going to tobacco control. So, for every dollar paid by the tobacco industry to the states, less than a dime is going to address the problem of tobacco use. Unless more of the settlement money is devoted to addressing the scourge of tobacco, future generations of children and adults will continue to needlessly suffer from tobacco-related disease and death. This represents an extremely costly missed opportunity.

We recognize and appreciate that there are many competing funding priorities at the state level but maintain that unless states begin to spend the CDC recommended amount of money on preventing and reducing tobacco use, both state and federal governments will continue to incur social and economic tobacco-related costs. Tobacco will cost the US economy approximately \$100 billion this year alone, and more than \$20 billion will come directly out of federal taxpayers' pockets for treating smokers under

Medicare, Medicaid, and the Veterans Administration health program. On average, each cigarette pack sold costs Americans more than \$3.90 in smoking-related expenses – an amount well in excess of the current average price of a pack of cigarettes. As a nation, we cannot afford to continue to incur the huge human and economic losses due to tobacco use.

The CDC recommends that states establish tobacco control programs that are comprehensive, sustainable, and accountable. ACS and the public health community have long-advocated that a comprehensive approach to tobacco control be implemented at the local, state, and federal level. As part of this advocacy, the Society urges that the needs of special populations be taken into consideration when tobacco control programs are developed and implemented. To be responsible and responsive, tobacco control efforts at the local, state, and national level must address the unequal burden of tobacco-related disease on our nation's minority, ethnic, and medically underserved populations. A guiding principle of these efforts should be the reduction of disparities in tobacco use, tobacco cessation, and health outcomes. ACS supports the best practices outlined by the CDC for comprehensive tobacco control programs and calls on Congress and state governments to ensure that adequate resources are provided so that each state can develop and fully implement a program that contains the following components:

- (1) **Community-programs to reduce tobacco use** – community involvement is essential to reducing tobacco use and local government entities, community and business leaders, health care providers, community organizations and others can be effective partners and should be engaged in tobacco prevention and cessation activities;
- (2) **Chronic disease prevention/health promotion programs to reduce the burden of tobacco-related diseases** – this includes cancer registries which help public health professionals determine cancer patterns among diverse populations, monitor cancer trends, target and evaluate cancer prevention and control programs (including tobacco control efforts), make rational decisions about resource allocation, and advance epidemiological, clinical, and health services research;¹

¹ In 1992, *Reader's Digest* claimed, "a network of cancer registries can be our most potent new weapon against cancer." Since then, Congress gave CDC the authority to expand cancer registries to every state. Unfortunately, current funding is inadequate to support this registry network, resulting in the closure of some regional registries. In order to reverse this trend, the American Cancer Society urge Congress to provide \$55 million in funding for FY 2001 to expand and improve the collection of information gathered by CDC's state-based cancer registry program.

- (3) **School-based health programs to prevent tobacco use and addiction** – the Surgeon General’s recent report on Reducing Tobacco Use found that “educational strategies, conducted in conjunction with community and media-based activities, can postpone or prevent smoking onset in 20 to 40 percent of adolescents”;
- (4) **Enforcement of tobacco control policies** – enforcement of tobacco control policies at the local and state level helps ensure their effectiveness by both deterring violators and communicating to the public that these policies are important and a priority of the community;
- (5) **State-wide programs and projects for greater capacity and reach** – state-wide initiatives that involve the public and private sector can increase the capacity of local programs by providing technical assistance and imparting lessons learned, exchanging contacts in particular communities and organizations, and sharing expertise;
- (6) **Counter-advertising/counter-marketing to counteract pro-tobacco influences and increase pro-health messages** – the Surgeon General also recently reported that efforts to prevent tobacco use face the “pervasive, countervailing influence of tobacco promotion by the tobacco industry.” Current scientific suggests that population-based measures involving a combination of policy and media interventions are the most cost-effective method to decrease tobacco use, particularly among children. Therefore these efforts must be increased;
- (7) **Tobacco use cessation programs to help the 50 million Americans currently addicted to tobacco to successfully quit** – more than 70 percent of all current tobacco users have indicated a desire to quit and helping them to quit. Helping them to quit can save money and save lives as cessation treatment and therapy is proven to be cost effective;
- (8) **Surveillance and evaluation to ensure fiscal oversight and effectiveness of programmatic efforts** – monitoring and evaluation of each component of a comprehensive tobacco control program permits policymakers and program staff to adjust and improve activities and ensure that public money is being spent in a responsible and effective manner;
- (9) **Administration and management for sound program development, implementation, and oversight** – experience from California and Massachusetts suggests that program success partially depends upon sufficient staffing and adequate management infrastructure.

ACS is pleased that a handful of states (California, Massachusetts, Florida, and Oregon) have taken the steps necessary to move their states toward comprehensive tobacco control programs that are

beginning to see tangible results. However, despite the availability of new evidence and potential new funding for effective tobacco control efforts, no state is currently implementing all of the CDC recommended program components fully. With only seven states allocating even the minimum amount of funding recommended by the CDC for tobacco control, it is not surprising that there is not one state-based tobacco control program that conforms to the CDC's best practices guidelines for tobacco control.

The American Cancer Society is disappointed with this overall "state of the states" with regard to tobacco control and is extremely concerned about the short-term and long-term health consequences of this failure to invest adequately in preventing and reducing tobacco use among both children and adults.

ACS State-based Efforts to Secure MSA Funding for Tobacco Control

These disappointing results are certainly not for a lack of effort on the part of ACS and our public health partners. Since the MSA was signed, ACS staff and volunteers have worked tirelessly with legislatures in all 50 states to secure adequate appropriation of tobacco settlement funds for comprehensive tobacco control programs. For the past two years, this issue has dominated our public policy agenda across the country. We have educated the public through town hall meetings and mass media, organized coalitions with literally hundreds of youth, health, education, and social service organizations to send a singular message to each legislative body, and hired additional staff to press each state to fund a sustainable, comprehensive statewide tobacco control program that meets minimum CDC requirements. Most importantly, we have collaborated with state health departments to develop concrete plans to implement comprehensive community tobacco control programs that meet national standards for effectiveness and demonstrate good stewardship of state dollars.

Yet, for the most part, our calls to action for policy makers to take advantage of this once-in-a-lifetime opportunity to end the scourge of tobacco and to decrease health care costs for generations to come have fallen on deaf ears. While a small number of states have invested tobacco settlement funds at a level sufficient to implement a statewide tobacco control program, the vast majority have woefully under-funded this program area. In his recent report the Surgeon General wrote that "... [o]ur lack of greater progress in tobacco control is more the result of failure to implement proven strategies than it is the lack of knowledge of what to do ... Tobacco use will remain the leading cause of preventable illness

and death in this Nation and a growing number of other countries until tobacco prevention and control efforts are commensurate with the harm caused by tobacco use.” The American Cancer Society has heeded Dr. Satcher’s call to level the playing field and we are working nationwide to help secure funding for comprehensive tobacco control efforts at a level commensurate with the damages tobacco inflicts.

I would like to share three specific state examples where the Society has dedicated significant resources in an effort to ensure that a meaningful portion of settlement dollars is dedicated to an effective tobacco use prevention and cessation program. In Maryland we have a positive example of a state that has made an investment sufficient to reduce tobacco consumption that will ultimately improve long-term health and decrease health care costs. As a second example, we call your attention to Kansas, which has earmarked money for tobacco control, but has done so at a nominal level leaving us little hope of impacting tobacco use rates. Third, in Connecticut, which since 1998 has received more than \$250 million in settlement funds, only \$5 million has been earmarked for tobacco control, of which only \$4 million has been expended.

In Maryland just this April, we saw many months of work come to fruition in the form of legislation that established long-term funding allocations for tobacco settlement payments. The funds will be spent on 20 health and education programs focused on three main issue areas: tobacco prevention, education, and cancer. In the first payment for program ramp-up, \$30 million was allocated to anti-cancer programs and \$16 million was allocated for tobacco programs. For the next ten years, approximately \$80 million annually is earmarked, \$50 million for anti-cancer programs and \$30 million for tobacco prevention programs, including \$10 million for a tobacco prevention media campaign. ACS proudly led the Maryland coalition that achieved this success, funded radio and print ads to educate the general public and legislators about the importance of spending settlement dollars wisely, and provided other resources to help advance this proposal through the legislative process. We are confident that the vision shown by Maryland policymakers this year will reduce suffering, save lives, and control health care costs for generations to come.

The Maryland model, however, is far too rare, and the Society’s experiences at the other end of the spectrum, have been far too prevalent. Take for example, Kansas, where the Society joined 44 other organizations, along with Kansas Attorney General (AG) Carla Stovall, to advocate funding for a

comprehensive statewide tobacco control effort at the CDC recommended minimum of \$18 million annually. Attorney General Stovall has a particularly keen interest in seeing that the money is spent in the spirit of the MSA, as she was the first Republican AG to enter the multi-state suit against the tobacco industry. Despite the multi-faceted citizen-based effort organized by a statewide coalition of which ACS is a member, a lingering budget crisis overshadowed the Kansas legislative session, and consequently a decision was made to put the first \$70 million of settlement funds into deficit reduction. The remaining tobacco settlement funding was divided among several issue areas focusing on children and juvenile crime, with only a fraction actually going to tobacco prevention. The mere \$500,000 allocation is well below the amount CDC recommends that Kansas invest in a comprehensive tobacco control program.

While the programs established to enhance the lives of children will benefit the future of Kansas, they unfortunately will do nothing to reduce the human and economic toll that tobacco takes on Kansans. Thus, in Kansas, the tobacco use problem will continue unabated unless the state significantly increases the tobacco control appropriations budget line in the next legislative session.

The outcome of the state settlement funding fight in Connecticut has been one of the most disappointing experiences for the Society volunteers and staff working at the state level to secure settlement money for comprehensive tobacco control programs. Connecticut consistently ranks as the country's wealthiest state in terms of average and disposable income, and since 1995 the state has enjoyed a budget surplus. In 1995, ACS partnered with Connecticut Attorney General Richard Blumenthal to form a statewide coalition known as MATCH (Mobilize Against Tobacco for Children's Health). Since then, the MATCH Coalition has grown to include more than 70 statewide agencies, with ACS often serving as the coalition's official voice.

Attorney General Blumenthal, while one of the first state AGs to sue the tobacco industry, was also the very last to sign onto the MSA because he was not convinced that individual state legislatures and governors would spend the money for the purpose the MSA was negotiated – to keep children from becoming addicted to tobacco and to alleviate the financial and social burden caused by tobacco use. To date, Attorney General Blumenthal's fears have been realized – especially in his home state. Despite the fact that the MATCH Coalition, unified with one voice, asked the state legislature and the governor for the CDC recommended minimum of \$21 million to carry out a comprehensive tobacco control program,

the state failed to meet the challenge. During the 2000 legislative session, although Connecticut received approximately \$110 million in settlement funds, the state failed to dedicate any funding toward state tobacco control efforts. In fact, \$1 million still remains unspent from the original \$5 million allocated to tobacco control in 1999, the only settlement dollars yet to be dedicated to tobacco control in Connecticut.

We are deeply concerned that our experiences in Connecticut and Kansas have been more common than that in Maryland. As detailed in the Campaign for Tobacco Free Kids report released this week, only seven states have invested enough to ensure decreased tobacco use rates, and only eight more have appropriated enough to stand a chance at affecting a real change in tobacco use rates. This nation deserves better. It is a national shame that only 15 states have taken steps to reap long-lasting benefit from the largest health-related legal settlement in history.

The American Cancer Society stands willing and able to help develop and implement effective comprehensive tobacco control programs in each state and county in this country. However, it appears that without a significant shift in the attitudes and priorities of policy makers at all levels of government, the historic opportunity to reverse our nation's largest health burden will be wasted.

Congressional Role in Tobacco Control

While the states have an important role to play in tobacco control, this is also a national and global issue in which Congress has an absolutely critical role to play. In this respect, Mr. Chairman, the American Cancer Society appreciates the leadership role you have played in addressing tobacco control from a national perspective, and we look forward to working with you and your colleagues to pass effective tobacco control legislation. With your indulgence, I will briefly discuss several essential policies that can only be effectively implemented at the federal level.

First, we must have strong, effective, meaningful regulation of tobacco products by the Food and Drug Administration (FDA). The nation's deadliest consumer product cannot continue to be totally unregulated. FDA regulation over tobacco products should be consistent with the agency's regulation of

every other product intended for human consumption. Any deviation from agency precedent should be fully justified on public health grounds.

Federal funding for tobacco control and prevention programs is another priority. CDC, for example, plays a unique role in advising and assisting all states and territories in their tobacco control efforts. This federal role leverages state dollars and effectively weaves the state programs into a national program. Unless CDC's National Tobacco Control Program is adequately funded, state programs will fall short of their potential. ACS respectfully requests that Congress allocate this critical public health program \$130 million for FY 2001. Other federal agencies, including the National Institutes of Health and the Substance Abuse and Mental Health Services Administration (SAMHSA), also have important roles to play.² Federal funding for tobacco control programs remains far below the amounts justified by the magnitude of the problem and the opportunity we have to save lives and reduce suffering.

Congress also has an essential role to play in helping current tobacco users break their addiction. The federal government is the single largest provider and funder of health care services, yet the government's coverage of cessation benefits and services now falls far short of recommendations made by the Surgeon General and other leading health care experts. There is now overwhelming evidence that covering effective cessation is a good investment in both financial and human terms. Recent studies have shown that there are health benefits for individuals who cease their use of tobacco products, irrespective of their age at cessation. As mentioned above, approximately 70 percent of current tobacco users would like to quit and one barrier they experience is lack of insurance coverage for cessation. The "Medicare, Medicaid and MCH Smoking Cessation Promotion Act," sponsored by Senators Brownback and Durbin, would help provide Medicare and Medicaid beneficiaries and pregnant women served by state-based Maternal and Child Health Programs access to important tobacco cessation services and work to reduce and prevent tobacco-related illnesses and deaths among those populations.

The federal government also has an obligation to its taxpayers to hold tobacco companies accountable for their well-documented wrongdoing. Right now, the Department of Justice (DOJ) is

² This year, the American Cancer Society joined with more than 40 other cancer-related organizations in an unprecedented collaboration as "One Voice Against Cancer" to call upon Congress to appropriate a 15% increase for the National Institutes of Health (NIH), \$4.1 billion for the National Cancer Institute, and \$622 million for the cancer-related programs, including the National Tobacco Control Program, at the CDC.

pursuing Civil RICO charges against the tobacco companies. The federal judge overseeing the case ruled late last week that the RICO claim has legal merit. Unfortunately, tobacco industry allies in Congress have been trying to block funding for this lawsuit. This would effectively give the tobacco companies immunity for their violation of federal laws, and would deny American taxpayers their day in court. We urge Congress to provide the DOJ funding to pursue the RICO claims in FY 2001 and beyond, as necessary.

Another important tool to hold tobacco companies accountable is to impose prospective penalties on companies based on their share of the illegal youth market. This would reverse the perverse economic incentives now in place and stimulate the companies to compete with one-another to reduce their share of the youth market. Unfortunately, this measure has not yet been embraced by Congress.

There is a whole range of international tobacco control issues that also remains the responsibility of Congress, rather than the states. For example, negotiations begin in Geneva next week on a global treaty to promote tobacco control across borders. Congress has a proper role ensuring that the US plays a leading role in encouraging a strong, effective treaty. There are many other ways that Congress can promote tobacco control, multilaterally, bilaterally and unilaterally.

Please note that this is not an exhaustive list of issues that must be addressed by Congress. I have not touched on the need for higher federal tobacco taxes to reduce consumption, especially among children; stronger tobacco product warning labels; safeguards to prevent Internet tobacco merchants from preying on children and violating tax laws; stronger restrictions on tobacco advertising that harms children; and limits on candy-flavored bidi cigarettes and other youth-oriented tobacco products.

As you know, despite the historic settlement with the states, the tobacco industry and its products continue to wreak havoc on the health of our nation. While the public health community and many of our nation's public health and policy leaders had high hopes that the settlement would be the magic bullet to our nation's tobacco woes, it is clear that we continue to have our work cut out for us.

Conclusion

Mr. Chairman, we believe that it is imperative that the states set-aside the CDC recommended amount for comprehensive sustained tobacco control efforts. ACS remains committed to working at the state level to ensure that adequate resources are appropriated to fund both state and local efforts to prevent and reduce tobacco use among both children and adults. Our state-based staff are dedicated to ensuring that a majority of states – sooner rather than later – make significant investments of their settlement money into comprehensive, tobacco control programs that adhere to the best practices as outlined by the CDC.

However, equally important to this effort is the role of Congress in enacting complementary policies and programs. While we recognize we are in the waning days of the 106th Congress, we respectfully call upon Congress to ensure that CDC is provided adequate funding to support both state-based tobacco control and cancer registry efforts which will work to ensure that states have high quality, timely data and technical assistance to bolster their tobacco control efforts. And, as planning begins for the next Congress, we urge you to once again join with the public health community in providing meaningful regulatory authority for the FDA.

ACS looks forward to working with you and your colleagues in the 107th Congress to address many of the other issues I have outlined today in my testimony. We stand ready to work with you to protect our children from tobacco use and to help those currently addicted to quit. With this federal-state, public-private partnership, we will surely save both lives and money from a significant reduction in tobacco-related disease.

Mr. Chairman and Members of the Committee, please know the American Cancer Society sincerely appreciates the opportunity to present our views and thanks you for taking the time of our your schedules at this busy time of year to hold a hearing on this most important public health issue.

I shall be pleased to answer any questions you may have.